

COMMONWEALTH OF VIRGINIA
VIRGINIA BOARD OF DENTISTRY
9960 MAYLAND DRIVE, SUITE 300
HENRICO, VA 23233-1463
804-367-4538
www.dhp.virginia.gov/dentistry

A completed application shall include the following unless stated below. An incomplete application and/or fee will delay the processing of your application. Incomplete applications are kept for one year then destroyed.

INSTRUCTIONS FOR REINSTATEMENT OF DENTAL LICENSE:

- _____ **1.Reinstatement Application:** Please be sure that all information is completed on the application.
- _____ **2.Fee for applicant due to lapse of license:** The reinstatement fee for a **dental license is \$500** and must be paid with a certified check, cashier's check or money order, made payable to the **Treasurer of Virginia**. The fee can be used for one year from date of receipt. Pursuant to 18VAC60-21-40(G), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.
- Fee for applicant due to previously revoked or indefinitely suspended license:** The reinstatement fee for a previously revoked dental license is **\$1,000** and the fee for a previously indefinitely suspended dental license is **\$750**.
- _____ **3.Form B Chronology:** List **ALL** activities since receiving your degree or certification. (*Resumes and curriculum vitas are not accepted as substitutes for completing the chronological listing and will not be considered.*)
- _____ **4.Form C: Original** licensure verification from any jurisdiction in which you currently hold or have ever held a license/registration/certification to practice dentistry or as another health care professional. Copies of permits are not accepted. Verification cannot be older than 6 months from date prepared.
- _____ **5.Original**, current report, not older than 6 months, must be obtained by Self Query from the National Provider Data Bank (NPDB), which may be requested through their website at <http://www.npdb.hrsa.gov/>. There is a fee for this report. **This report from the NPDB is required from all applications, without exception** (Regulation 18VAC60-21-190.3).
- _____ **6.**Please be aware that your signed and notarized application affidavit authorizes the release of confidential information, affirms that your application is complete and correct, and attests that you have read and understand and will remain current with the laws and regulations governing the practice of dentistry in Virginia.
- _____ **7.Name Change:** Documentation must be provided to show each name change(s) if your name has ever been changed from the most recent time you held an active license in Virginia or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

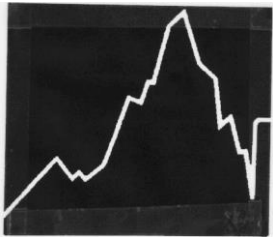
_____ **8. Continuing Education:** You must submit documentation of having completed continuing education (CE) hours equal to the requirement for the number of years in which the license has not been active, not to exceed a total of 45 hours. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months immediately preceding the application for reactivation. Do not send original documents.

Submitted CE documentation **must** include the following:

- Your name
- Name of course completed
- Date(s) in which you completed the course
- Name of the course sponsor; and
- The number of CE credit hours earned

PLEASE NOTE:

- **To qualify for reinstatement of a license, the applicant must include documentation in the application sufficient to demonstrate continuing competence. Continuing education hours and evidence of active practice in another state or in federal service, recent passage of a clinical competency examination, a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association or current specialty board certification are considered in determining continuing competence. Completion of only home study, journal or internet courses is generally not sufficient to demonstrate continuing competence.**
- If your Virginia license has not been reinstated within six months of the Board's receipt of the application, certain portions of the application may need to be resubmitted before your application can be reviewed.
- You might obtain the Virginia laws and the regulations governing the practice of dentistry at www.dhp.virginia.gov/dentistry.
- To receive notice that your application has been delivered to the Board, it is suggested that the complete packet be mailed by "Certified Mail-Return Receipt Requested" or with "Delivery Confirmation".
- Within approximately 10 business of receipt of an application, applicants will be notified of missing application items.
- Documents submitted with an application are the property of the board and cannot be returned.
- Consistent with Virginia law §54.1.2400.02 and mission of the Department of Health Professions, addresses of licensees are made available to the public. Normally, the Address of Record is the publically disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publically disclosable address. Typically, this other address is the work or practice address. If you would like for you Address of Record to be made available to the public, complete both sections with the same address.



Virginia Board of Dentistry
Virginia Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
804-367-4538
www.dhp.virginia.gov/dentistry

APPLICATION FOR REINSTATEMENT OF DENTAL LICENSE

INSTRUCTIONS: Type or print clearly. Complete all sections. If the space provided for any answer is insufficient, complete your answer on a separate page, specify the number of the question to which it relates, sign the page and enclose it with the application.

I. GENERAL INFORMATION

Name: Last	First	Middle/Maiden	Suffix
Address of Record (Mailing Address)	City	State	Zip Code Telephone Number
Public Disclosable Address	City	State	Zip Code Telephone Number
Email Address:		Fax Number:	
Date of Birth ____/____/____		Social Security Number or Virginia DMV Control Number ____-____-____	
License Number	Date of Expiration	Name at time of Original Licensure:	

Please check below, if applicable:

- REINSTATEMENT REQUESTED DUE TO LAPSE OF LICENSE
- REINSTATEMENT REQUESTED DUE TO SUSPENSION
- REINSTATEMENT REQUESTED DUE TO REVOCATION

FOR OFFICE USE ONLY

FEE AMOUNT	APPLICANT NUMBER	DATE OF REINSTATEMENT
------------	------------------	-----------------------

NOTE: In accordance with §54.1-116 of the *Code of Virginia*, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires this number be shared with other agencies for child support enforcement activities.

3. APPLICANT HISTORY

ALL QUESTIONS MUST BE ANSWERED. If any of the following questions are answered "YES", explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits. Letters must be submitted by any treating professionals regarding health treatment and shall include diagnosis, treatment and prognosis.

a.	Have you ever been dropped, suspended, expelled or disciplined by any school or college for any cause whatever? If yes, give details, school(s); address and dates(s) on a separate page.	[] Yes	[] No																
b.	Has your practice of dentistry since expiration of your license been in the Commonwealth of Virginia? Is yes, give location. _____	[] Yes	[] No																
c.	Has any of your work since the expiration of your dental license been in any field other than the practice of dentistry? If yes, give details, jurisdictions(s) and date(s). _____ _____ _____	[] Yes	[] No																
d.	Have you ever announced yourself, or held yourself out, as being a specialist in any branch of dentistry? If yes, give specialty and jurisdictions _____	[] Yes	[] No																
e.	Have you ever been denied a license or the privilege of taking a dental licensure/competency examination by any licensing authority? If yes, give details, jurisdiction(s) and date(s). _____	[] Yes	[] No																
f.	List all jurisdictions in which you currently hold or have ever held a license/registration/certification to practice dentistry or as any other health care professional:																		
	<table border="1"> <thead> <tr> <th>Jurisdiction</th> <th>License Number</th> <th>Date Issued</th> <th>Expiration Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Jurisdiction	License Number	Date Issued	Expiration Date	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____		
Jurisdiction	License Number	Date Issued	Expiration Date																
_____	_____	_____	_____																
_____	_____	_____	_____																
_____	_____	_____	_____																
g.	Have you ever failed the dental licensing examination given for another jurisdiction? If yes, give details, jurisdiction(s) and date(s). _____	[] Yes	[] No																
h.	Have you ever been convicted of a violation of or pled Nolo Contender to any federal, state or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) if yes, give details, jurisdiction(s) and date(s) on a separate page, and include a copy of the disposition record certified by the Clerk of the Court.	[] Yes	[] No																
i.	Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or been requested to withdraw from the staff or any hospital, nursing home, other health care facility, or any health care provider? If yes, give details, jurisdiction(s) and date(s) on a separate page.	[] Yes	[] No																
j.	Have you ever voluntarily withdrawn from any professional society while under investigation? If yes, give details, jurisdiction(s) and date(s) on a separate page.	[] Yes	[] No																

k.	Have you ever had any of the following disciplinary actions taken against your license to practice dentistry, your DEA permit, Medicare, Medicaid or are any such actions pending; suspension/revocation, or probation, or reprimand/cease and desist or monitoring or practice, or limitation placed on scheduled drugs? If yes give details, jurisdiction(s) and date(s) on a separate page.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l.	Have you ever had any membership in a professional society revoked, suspended or sanctioned in any manner? If yes, give details, jurisdiction(s) and date(s) on a separate page.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
m.	Have you ever been a defendant in a military court martial or received medical or other than honorable discharge? If yes, give details, jurisdiction(s) and date(s) on a separate page.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
n.	Is there now, or has there ever been, in any jurisdiction, a complaint pending against your professional conduct or competence as a dentist? If yes, give details, jurisdiction(s) and date(s) on a separate page.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
o.	Have you ever had any malpractice suits brought against you? If yes, give details, jurisdiction(s) and date(s) for each suit on a separate page, and provide a letter from your attorney explaining each case.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
p.	Have you, within the last two (2) years, been physically or emotionally dependent upon the use of alcohol/drugs or been treated by, consulted with or under the care of a professional for any substance abuse? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment and prognosis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
q.	Have you ever received treatment for, or been hospitalized for, a nervous, emotional or mental disorder? If yes, provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment and prognosis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
r.	Do you have a physical disability, disease, or diagnosis which could affect your performance of professional duties within the last five (5) years? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment and prognosis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
s.	Have you ever been adjudged mentally incompetent, or been voluntarily or involuntarily committed to a mental institution? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide certified copies of all applicable court documents.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
t.	Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT
(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)**

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (Past and present) business and professional associates (past and present) and all governmental agencies And instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Dentistry any Information, files or records requested by the Board which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me in the application and supporting documents are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of dentistry and dental hygiene. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on www.dhp.virginia.gov, and

I have attached a certified check, cashier's check or money order in the amount of \$_____ made payable to the **Treasurer of Virginia**. I fully understand that funds submitted as part of the application shall not be refunded.

State of _____ _____
Signature of Applicant

County/City of _____

Sworn and subscribed to, before me, this _____ day of _____, _____.
Day Month

My commission expires on _____.

Signature of Notary Public

SEAL

COMMONWEALTH OF VIRGINIA
 BOARD OF DENTISTRY
 Department of Health Professions
 9960 Mayland Drive, Suite 300
 Henrico, VA 23233-1463
 (804) 3674538 www.dhp.virginia.gov/dentistry

FORM C
CERTIFICATION OF DENTAL BOARDS

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental/dental hygiene license. Some states require a fee, paid in advance, for providing this information. To expedite, you may wish to contact the applicable state board(s). Form C may be photocopied if copies are needed.

I am making application for licensure in Virginia by Reinstatement of Dental License:

I, _____, was granted License Number _____
 on _____ 19____ 20____ by the State of _____. The Virginia Board of Dentistry
 requests that I submit evidence that my license in the State of _____
 is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise directly to the
 Virginia Board of Dentistry. Your early attention is appreciated.

 Applicant's Signature

 Applicant's Typed/Printed Name

 Applicant's Address

Executive officer of State Board: Please complete and return this form to the applicant. If disciplinary action has been taken, return the form to the Board of Dentistry.

State of _____ Name of Licensee _____

Graduate of _____ License # _____ Issued _____

By Reciprocity Examination Endorsement with the State of _____

License is: Current-Expires _____ Active Inactive Lapsed-Expired _____

Has applicant's license ever been disciplined, suspended or revoked NO YES

If yes, give details and attach supporting documentation (Finding of Fact, Conclusions of Law, Orders): _____

Derogatory information, if any: _____

Comments, if any: _____

SEAL

 Signature

 Title

 Date

NAME OF LICENSEE _____ LICENSE NUMBER _____

